VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 29, 2012

Ms. Tammy Cota, Administrator
Cota's Hospitality Home
1079 South Barre Road
Barre, VT 05641

Dear Ms. Cota:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 11, 2012.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0365	A. BUILDING _____ B. WING _____	R-C 04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTA'S HOSPITALITY HOME	1079 SOUTH BARRE ROAD BARRE, VT 05641

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{R100}	Initial Comments: An unannounced on-site survey was completed by the Division of Licensing and Protection on 4/11/12 to follow up to the complaint surveys of 10/12/11 and 1/19/12. The following deficiencies are new or remain uncorrected from previous surveys.	{R100}		
{R128} SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that medications and treatments were administered in accordance with physician orders for 8 of 8 applicable residents in the sample.(Residents # 1, 2, 3, 4, 5, 6, 7 and 8). Findings include: 1. Per record review on 4/10/12, Resident #6, who has been experiencing increased ankle and foot edema secondary to chemotherapy, was examined on 3/29/12 by the attending physician's Physician Assistant who prescribed a change in medications and ordered "elastic stockings - knee high - on in the AM and Off at bedtime". As of 4/10/12, (12 days since receiving the order), the patient has not received the elastic stockings. This was confirmed during staff interview at 3:45 PM. 2. Per review on 4/10/12, Patient #8 has a	{R128}	POC accepted Karen Campos/Francis Kull	

TITLE 5/15/12 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PMC

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{R128}	Continued From page 1 physician order for Tylenol 325 milligrams (mg), 2 tablets PO (orally) every 4-6 hours PRN (as needed). When asked to provide the "stock" Tylenol used by the home when Tylenol is prescribed, staff identified a container of Tylenol with 500 mg tablets. The prescribed dose of 325 mg of Tylenol was not available for administration. 3. Per review on 4/10/12, Resident #7 is Vitamin D deficient and the physician has prescribed Vitamin D 50,000 units/1 capsule every 2 weeks. Review of the Medication Administration Record (MAR) notes during the month of February, the patient only received the medication once in February 2012. 4. Per record review on 4/10/12, Resident #1's physician wrote a new order during a visit on 11/16/11 that stated "Increase Vitamin D3, 50,000 units to 2X/week" due to levels being 'still low'. The order was never transcribed to the MAR and the resident has continued on the previously ordered dose of "Vitamin D3, 50,000 1X weekly" since that time. The failure to implement the new physician orders was confirmed during interview with the RN on 4/11/12 at 3:30 PM. 5. Per review of the medical record and the Medication Administration Record (MAR) for Resident #2 on 4/10/12, there were no written, signed physician orders on 3/22/12 to discontinue the current order for Fentanyl and start Methadone. Per review of the March 2012 MAR, the RN wrote next to the date of 3/22/12, "patch DC, will start methadone". The medical record included a progress note (3/14/12) by the RN that stated "I will ask the MD to phone in ....supply of Methadone....the order will be 5 mg. PO three times daily. D/C Fentanyl patch, TO Dr. -----."	{R128}		

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{R128}	Continued From page 2 There were no physician telephone orders in the medical record regarding these medications on either of these dates. During interview regarding the RN's discontinuation of the Fentanyl patch and the increase in dosage of methadone on 3/22/12, the RN confirmed on 4/11/12 ay 3:15 PM that she had never obtained a signed physician order for these medication changes. She stated that the physician was aware of a plan to make the changes, however, the orders were not obtained on 3/22/12, as written on the MAR. The physician wrote orders to start methadone 10 mg by mouth 3 times daily for 14 days on 3/30/12, during an office visit. 6. Per review of the medical record and the MAR for Resident #4 on 4/10/12, there was a physician's order for "Benadryl 25-50 mg. PO every HS (bedtime) PRN (as needed) for Insomnia". Per review of the April 2012 MAR, the PRN Benadryl was signed off as given on 4/2/12, however no information was recorded on the back of the sheet to relay the details. Per interview on 4/11/12 at 2:25 PM, the aide who administered the Benadryl to the resident confirmed that Resident #4 was having allergy symptoms and requested the Benadryl to alleviate them. The aide gave 25 mg. to the resident, and did not fill out the back of the MAR sheet to signify what dose, time, reason, or effects of the medication. The aide also stated that the reason listed to administer the PRN medication was "insomnia", that it was given sometime in the late afternoon, and not for the reason prescribed by the doctor. 7. Per review of the medical record, physician's orders, and the treatment sign off sheets for Resident #3 on 4/10/12, the MD ordered daily foot soaks and application of a medicated ointment to	{R128}		

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{R128}	Continued From page 3 an infected toenail. Per review of the treatment sheets, the foot soaks and ointment application as well as signs of infection, skin condition, and pain status, were not signed off as being completed on a number of days. Per review, the treatment sheet was not filled in and /or signed as completed on 3/15/12-3/18/12. There was also missing documentation on 3/24/12, 3/25/12, and 3/29-3/31/12. Per interview on 4/11/12 at 2:45 PM, the registered nurse confirmed that the documentation of the treatment per physician's order was not complete on the treatment sheet on the days listed above. 8. Per review of the medical record, the physician's orders, and the MAR for Resident #5 on 4/10/12, the physician wrote an order on 11/8/11 for "Klonopin 0.5 mg, one PO BID [twice daily] PRN/ anxiety, insomnia". The MAR for December 2011 showed an entry for "Clonazepam PO PRN 0.5 mg". There was no frequency listed or reason to give the medication listed on the MAR. Per further review, the medication was signed off as given on 12/9/11, with no entry on the back of the sheet to show what time, reason, or effect of, the medication administered. Per interview on 4/11/12 at 2:50 PM, the registered nurse confirmed that the order was not transcribed to the MAR with all the required elements of the medication order, and that staff had not signed the back of the sheet with the information regarding time and effect of the PRN medication given.	{R128}		
{R145} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for	{R145}		

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{R145}	Continued From page 4 each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the nurse failed to oversee the development of a written plan of care to reflect specific care needs and monitoring of health conditions for 1 of 8 applicable residents in the sample. (Resident # 8) Findings include: Per record review on 4/10/12, Resident #8 received treatment in the Emergency Department of a local hospital for an upper respiratory infection with bronchospasms. The resident was prescribed an antibiotic, inhalers, cough medicine, Prednisone and Potassium supplement and continuous nasal oxygen. The care plan did not reflex the resident's recent illness and the specific care needs and monitoring of the resident's condition. There was no reference on the care plan identifying the resident's use of oxygen and the responsibilities of staff regarding the maintenance of the oxygen equipment, testing of the resident oxygen saturation levels, assessing breath sounds and monitoring the resident's temperature.	{R145}		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken;	R150		

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R150	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that documentation of action taken after a resident incident was recorded in the medical record for 1 of 8 residents in the sample. (Resident #2) Findings include: Per record review on 4/10/12, Resident #2 experienced a fall/fainting episode after attempting to self administer a topical pain medication on 3/9/12. Although the incident is documented in the progress note dated 3/9/12, staff failed to document physician notification. During interview on 4/11/12 at 3:30 PM, the RN stated that she had been notified of the incident and did notify the physician, although she had failed to document that fact in the medical record.	R150		
{R161} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that all medications were handled according to the home's policies and procedures for 1 of 8 applicable residents in the sample. (Resident #2) Findings include: 1.a. Per record review on 4/10/12, the	{R161}		

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{R161}	Continued From page 6 Registered Nurse (RN) wrote in a progress noted dated 3/9/12 to "D/C Fentanyl patch (an opioid pain reliever) TO [telephone order] Dr. -----". There was no corresponding telephone order form completed and sent to the physician for signature, per review of the facility's Policy on Telephone Orders. The failure to transcribe the telephone order correctly and send to the physician for signature within 15 days was confirmed during interview with the RN on 4/11/12 at 3:15 PM. Refer also to R128 b. Per record review on 4/10/12, a caregiver documented in a progress note on 3/9/12 that Resident #1 was given a duragesic patch (Fentanyl pain medication) to take with him/her to self administer (apply) while out of the facility at an appointment. During interview at 11:30 AM on 4/11/12, the care giver stated that the medication patch was scheduled to be applied at 12:30 PM on 3/9/12 and so he/she had given it to the resident to self apply and take with him/her. There was no physician order for this resident to self administer medications and there was no RN assessment of the resident's ability to safely self administer medications. Per review on 4/11/12, the facility's Safe Medication Administration Policy stated "if the resident is going to be absent from the facility when medications are due....the resident must be deemed as appropriate for self administration". During interview at 3:30 PM the same day, the RN confirmed that this resident was not 'deemed' appropriate for medication self administration.	{R161}		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R162		

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R162	Continued From page 7 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the manager of the home failed to assure that all resident medications administered by staff had a written, signed physician order in the medical record for 1 of 8 applicable residents in the sample. (Resident #1) Findings include: Per record review on 4/10/12, Resident #1 was administered liothyronine sodium 25 mcg., 1/2 tab (12.5 mcg.) by mouth daily and there was no written, signed physician order in the medical record. Per interview at 12:15 PM the same day, the caregiver confirmed the lack of a signed, physician order for this medication.	R162		
{R189} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.	{R189}		

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{R189}	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure staff progress notes were documented to include changes in the resident's condition or description of resident absence and why medications were not administered for 1 applicable resident (Resident # 7). Findings include: Per record review on 4/10/12, documentation on the Medication Administration Record for February 2012 for Resident #7 notes the resident is LOA (leave of absence) from 2/1/12 through 2/8/12 and 2/25/12 through 2/29/2012. No explanation is provided in the record regarding the residents location during the LOA and whether s/he has a means to receive their medications. Per interview on the afternoon of 4/10/12, the owner of the home confirmed the resident leaves and stays with his girlfriend.	{R189}		
{R190} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure the completion of all required background checks for 5 of 6 employee personnel records reviewed. Findings include: Per review of 6 employee files for evidence of required background checks, only 1 of 6 had evidence that the required background checks	{R190}		

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{R190}	Continued From page 9 were completed. During interviews with the owner/managers on the morning and afternoon of 4/11/12, each confirmed that the required checks were not available/completed as required by Vermont Residential Care Home Licensing Regulations. This deficiency remains uncorrected from the survey of 1/19/12.	{R190}		

1079 So. Barre Rd. Barre , VT 05641
802-479-3118
Cotashh@gmail.com

Plan of Correction
Health Survey form April 11, 2012

V. Resident Care and Home Service

5.5 General Care

R 128 1. Resident #6: The Elastic stockings have been purchased for this resident. They are in use per orders. Patient education was given by nurse and doctor. The nurse will monitor use and effectiveness weekly. Staff will sign off on treatment sheet. Staff have been in-serviced about the treatment at the monthly staff meeting 05/10/12. This will be overseen by the nurse and Manager.

2. Resident # 8: Nursing has obtained a bottle of Tylenol 325 mg tablets for this resident. The Nurse will reorder medication as needed. This is completed. This will be overseen by the nurse.

3. Resident # 7. RN will be educating staff on signing off medications and treatments at the next staff in-service May 10th. The nurse or manager will monitor staff compliance. New orders will be placed in the MAR book to highlight the change. This is complete and will be overseen by nursing.

4. Resident # 1 Nursing has clarified this order with resident's physician and pharmacy. This medication is now being dispensed as prescribed by the doctor. This is correct on the MAR and complete. This will be overseen by Nursing.

5. Resident #2 Nursing has clarified that the correct doctor's order was received. The order has been received and is on file. This is complete and will be overseen by nursing.

6. Resident #4 The education for PCA's has been completed by the RN on 05/10/12 at the monthly staff meeting. RN is working on new set of standing orders with taking surveyors suggestions into account. This will be completed by June 15th. This will be completed by the RN.

7. Resident # 3 A review with staff by the RN about signing off all meds and

treatments has been done at 5/10/12 staff meeting. Individual staff members have been educated about the Treatment Sheet. The importance of performing and signing treatments off were emphasized. Treatment sheets are now in the MAR for more visibility and better communication. This is complete and will be overseen by nursing.

8. Resident #5 Nursing has clarified the order with doctor and pharmacy. Nursing has made sure order is correct on MAR. Nursing will monitor MAR routinely to verify orders are correct on the MAR. This is complete and will be overseen by nursing.

5.9C (7)

R145 1. Resident #8 Nursing has updated Plan of care for this resident. The staff will monitor resident's vital signs, weight, and oxygen saturations daily. This will be recorded on flow sheets as directed by Nursing and/or physician. Staff have been educated by Nursing about this monitoring. This was completed at May 10, 2012 staff meeting. This will be overseen by nursing.

5.9C (2)

R150 1. Resident #2 The staff member responsible for notifying a resident's physician of an occurrence will document immediately upon notification. Staff have been educated of procedure at staff meeting 5/10/2012. This will be overseen by Nursing.

5.10 A/B

R161 1. Resident #2 Nursing has received order and put on file. Review of polices have been done at 5/10/2012's staff meeting. This is complete and will be overseen by Nursing.

5.10

R162 1. Resident #1 Nursing has clarified Order with Physician. The correct order is on file. This is complete. This will be overseen by nursing.

5.12.b (3)

R189 1. Resident # 7 A Resident's Leave of Absence will be documented when they leave facility. Information to be documented is as follows: date, time leave begins, expected time of return, responsible person for medications, medications that were dispensed, and a contact number for the responsible person. This information is to be recorded in the chart. Staff have been educated about this procedure at 5/10/2012 staff meeting. This will be overseen by nursing.

5.12.b (2)

R190 1. The manager has completed the criminal, child and adult registry checks. They are on file. Nursing has verified that this is complete. The manager will

oversee back grounds in the future.

Cota's Hospitality Home
Tammy Cota -Manager

Tammy Cota 5/15/12

POC accepted
Karen Campos
5/18/12